Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS649HOS	A. BUILDING _____ B. WING _____	C 06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH VISTA HOSPITAL	1409 EAST LAKE MEAD BLVD NORTH LAS VEGAS, NV 89030

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S 000	Initial Comments This Statement of Deficiencies was generated as the result of a complaint investigation survey conducted at your facility on 06/11/08 and 06/12/08. The state licensure survey was conducted in accordance with Chapter 449, Hospitals, adopted by the State Board of Health December 11, 1998 last amended September 27, 1999. The census at the time of the survey was 135 patients. The following complaints were investigated: Complaint #16697- Unsubstantiated Complaint #17115- Substantiated (See Tag: S146) Complaint #17023- Unsubstantiated Complaint #18273- Substantiated (See Tag: S279) Complaint #18439- Unsubstantiated Complaint #15521- Unsubstantiated Complaint #17695- Unsubstantiated Complaint #15595- Unsubstantiated Complaint #17078- Unsubstantiated Complaint #16740- Unsubstantiated Complaint #18056- Unsubstantiated Complaint #16886- Substantiated (See Tag: S310) Complaint #16991- Substantiated (See Tag: S310) Complaint #16611- Unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal,	S 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 000	Continued From page 1 state or local laws. The following regulatory deficiencies were identified.	S 000		
S 146 SS=D	NAC 449.332 Discharge Planning 4. An evaluation of the needs of a patient relating to discharge planning must include, without limitation, consideration of: (a) The needs of the patient for postoperative services and the availability of those services; (b) The capacity of the patient for self-care; and (c) The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge. This Regulation is not met as evidenced by: Based on record review the facility failed to ensure the appropriate placement of a patient after discharge (Patient #9). Findings include: Patient #9 was admitted to the facility on 05/03/07 with a diagnosis including Psychosis and Dementia. The physicians discharge summary dated 05/16/07, documented the patient continued to exhibit short term memory impairment, poor functioning level, declining memory and could not care for herself. The Hospital Gero-Psychiatric Nursing Intake evaluation form dated 05/03/07, indicated Patient #9 was orientated to person only and did not know the address, city or state she resided in. Patient #9 exhibited confusion, poor memory and anxiety on admission.	S 146		

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S 146	Continued From page 2 The Hospital History and Physical on Patient #9 dated 05/03/07, indicated a diagnosis including Psychosis, Dementia, Anxiety Disorder and Panic Disorder. Patient #9 was admitted due to difficulty caring for herself and panic attacks. The Hospital psychological evaluation on Patient #9 dated 05/03/07, indicated Patient #9 was admitted on a legal 2000 after displaying paranoid behavior and an inability to care for herself. The patient exhibited paranoid behavior reporting she was being held captive at a group home and her belongings and money were being stolen. The patient reported she did not want to return to the group home. Physician Progress Notes dated 05/04/07 to 05/14/07, indicated Patient #9 showed signs of confusion, paranoia, and poor cognitive functioning during her stay at the hospital and was unable to care for herself. Physician Discharge/Transfer Summary dated 05/16/07, revealed Patient #9 exhibited signs of short term memory impairment, poor functioning level and declining memory. The patient would forget things that she said after a couple of minutes and although her memory had not improved much it was deemed the patient had gained the maximum benefit from her hospital stay and would be discharged to a group care home. The case management note dated 05/16/07, indicated the patient was discharged to a group home which was licensed as a residential facility to provide care for elderly or disabled persons, category 1 residents. The facility was not licensed to care for persons with mental illness, dementia	S 146		

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S 146	Continued From page 3 or Alzheimer disease. Severity: 2 Scope: 1 CPT # NV17115	S 146		
S 279 SS=G	NAC 449.358 Medical Staff 5. The medical staff is accountable to the governing body for the quality of the medical care provided to the patients of the hospital. This Regulation is not met as evidenced by: Based on interview and record review the medical staff failed to be accountable to the governing body of the facility for the quality of medical care provided to a patient (Patient #4). Findings include: 1. On 06/11/08, Patient #4 reported being admitted to the Hospital on 12/06/07 with a diagnosis of Atrial Fibrillation (irregular heart beat) and treated with medication and cardioversion (electrical shock of heart). Patient #4 reported she received an echocardiogram (diagnostic method to visualize heart) while at the hospital that revealed the mitral (left heart valve) and tricuspid valve (right heart valve) in her heart were defective and may require replacement but was never notified of the results. The patient reported she was discharged with medication and a physician follow-up visit. The patient was admitted to another hospital on 01/12/08 with congestive heart failure that required open heart surgery and replacement of the mitral valve and repair of the tricuspid valve. 2. On 06/12/08 at 3:00 PM, Physician #1 reported he evaluated Patient #4 in his office for a follow-up visit after her discharge from the	S 279		

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S 279	Continued From page 4 hospital. Physician #1 indicated the patients discharge summary had no mention of the heart valve problems or echocardiogram results. Physician #1 reported he would have recommended surgical consultation if he had been aware of the extent of the patients heart valve problems. 3. The Hospital echocardiogram report dated 12/06/07, revealed moderate to severe mitral valve regurgitation and moderate to severe tricuspid valve regurgitation. The Hospital cardiology progress note by Physician #3, dated 12/07/07, documented the patient's moderate to severe mitral and tricuspid valve disease. The Hospital discharge summary by Physician #3 dated 12/10/07, did not reveal the findings of the echocardiogram completed on 12/06/07 and did not document any heart valve disease. The left heart catherization report dated 01/14/08, from another hospital revealed cardiomyopathy (disease of heart muscle) and moderate to severe mitral and tricuspid valve regurgitation requiring heart valve replacement. The hospital discharge summary by Physician #7, dated 02/15/08, revealed cardiovascular surgery with mitral valve replacement and tricuspid valve repair was completed and instructions for Patient #4 to follow-up with a cardiologist (heart specialist). Severity: 3 Scope: 1 CPT #NV18273	S 279		

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S 310	Continued From page 5	S 310		
S 310 SS=G	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on interview and clinical record review, the facility failed to ensure the needs of the patient was continually assessed by qualified hospital personnel throughout the patients contact with the hospital. Findings include: 1. Policy and Procedures Title: Pressure Ulcer, Skin Care Protocol: Revised 1/2003 "Purpose of Policy... To provide (standard) guidelines (related to providing care for patients with skin tears, perineal excoriation and for) identification of patient at risk of developing pressure ulcers and prevent the occurrence of facility acquired pressure ulcers. Implement the corresponding assessment, staging and treatment procedures, and assure uniform procedures are followed for skin tears, perineal excoriation, pressure ulcers and those at risk for skin breakdown. Procedures... 9. The licensed professional will evaluate areas	S 310		

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S 310	Continued From page 6 of compromised skin and document findings utilizing appropriate skin assessment flow sheet each shift. Such documentation will include, but is not limited to: a) Date and time of assessment. b) If the wound/ ulcer was inherited or acquired. c) Measurements of size Stage, site and photographs of the wounds both upon admission and as required throughout the hospital stay. d) appearance of the wound to include exudates, bleeding, eschar, epithelialization, sloughing, granulation, tunneling, undermining, necrotic tissue, pain (using approved pain scale), condition of surrounding skin, and age/onset of wound, if known, etc. 10. Reassessment of wounds, with photographs, will be accomplished each week on Thursday. Photographing Wounds... Note: Patient Consent for photographs of wounds and ulcers is not required. Polaroid cameras are available on each unit for documenting photographically each wound found on a patient. Such photographs must be stamped with the patient's nameplate, dated, and initialed by the licensed professional who carries out the photographing. Fresh photographs of each wound will be taken every 7 days, on Thursday when the dressings are to be changed. Each photograph must include the following information: 1. Wound site 2. Tissue involvement and description of surrounding tissue. 3. Wound measurements 4. Presence of tunneling or undermining. 5. Color and type of tissue in the wound 6. Exudates.	S 310		

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S 310	Continued From page 7 7. Odor 8. Name of person taking the photographs. 9. Signature of licensed professional 10. Patient's name or med # and date. Skin Tears... Note: Skin tears are not staged. 1. Change dressing PRN (as needed) to 7 days 2. Cleanse skin tear with normal saline 3. Dry skin abrasion with sterile gauze sponges 4. Apply topical antibiotic per physician order. 5. Apply sterile, dry, non- adherent, non aggressive dressing and secure appropriately. 6. Document treatment and findings. 2. Patient #5 was a 57 year old male admitted to the emergency room on 12/15/07 from a local nursing home for repair of suture to the left side of the forehead. The diagnoses were Hepatic Encephalopathy, Heal Laceration with Bleed, Coagulopathy secondary to End-Stage Liver Disease, Diabetes Mellitus, History of Congestive Heart Disease, Portal Hypertension secondary to End-Stage Liver Disease, Anemia and Thrombocytopenia. The Emergency Room Visit Record, dated 12/15/08, revealed: " Patient from _____(name of the long term facility) for suture repair to left side of forehead. states fell couple of days ago, patient pulled off steri strips now bleeding unable to stop." The admission history and physical dated 12/16/07, completed by the physician revealed: "the patient was a male with a history of cirrhosis of the liver due to alcohol abuse and coagulopathy, esophageal varices, status post banding, chronic anemia, diabetes mellitus was	S 310		

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transferred to the emergency room for bleeding from the head wound. Apparently the patient had sustained a laceration 2 days ago to his forehead. The wound started to re-bleed. It could not be stopped by the staff nurses so he was transferred to the emergency room. In the ER (emergency room), the patient was found to be obtunded, jaundiced with a respiratory rate of 6. Pressure dressing was applied on the forehead. The patient was admitted to Intensive Care Unit for monitoring."

On 12/16/07 at 03:40 (3:40AM), the licensed nurse identified on the nursing flow sheet: under the section entitled incisions/wounds...
*Head -wound -appearance unapproximated
*Head wound length and width measured 1.5cm
*Surrounding areas- intact
*Head Dressing status- dry and intact
*Head Drainage: none
*Closure status intact.
*Wound dressing dry and intact checked ace wrap- 4x4s.

On the Nursing Flow Sheet, licensed nurse identified the following documentation:

On 12/17/07 at 11:01AM, the licensed nurse identified: "medial tear on the coccyx area and pressure sore on the coccyx Stage II; and a large scar and large lump located on the abdomen. There was no documented evidence to verify the licensed nurse assessed the condition of the pressure dressing located on the left forehead."

On 12/17/07 at 2000 (8:00PM), the licensed nurse documented: "the head bandaged."

On 12/18/07, at 0300 (3:00AM)the licensed

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nurse documented: "no discomfort had relaxed body."
On 12/18/07, at 0400 (4:00AM), the licensed nurse documented: "non verbal /guarding frontal lobe of head."
On 12/18/07 at 1200 (12:00PM), the licensed nurse documented: "pressure sore located on the Coccyx Stage II." The licensed nurse initiated skin interventions. There was no documented evidence to verify the skilled nurse assessed the wounds on the forehead after 12/17/07 at 8:00PM.

On 12/18/07, a photograph was taken of the patient's forehead. There was one area on the right side of the forehead the size of a silver dollar and on the left side a red area the size of a fifty cent piece. The photograph was not signed by the photographer and the time the photograph was taken was not documented. The staff member who photographed the patient did not follow hospital protocol for wound care documentation. There was no documented evidence to verify the licensed nurse assessed and addressed the possible cause of the two wounds noted on the forehead

On 12/18/07at 1800 (6:00PM), the licensed nurse documented: "...S.O. (significant other) is concerned about patient's head, stating 'I was never told by the nursing home that my husband fell'..." There was no documented evidence to verify the skilled nurse assessed the head bandage after 12/17/07 at 8:00PM until the wife visited on 12/18/07 at 1800.

On 12/19/07 at 0715 (7:15 AM), the licensed nurse identified "2 wound spots on forehead, may have been blisters." The licensed nurse did not follow hospital protocol for wound care

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S 310	Continued From page 10 documentation. The staff member who photographed the wounds on the forehead failed to assess the two spots on the forehead and notify the physician. CPT#NV16886 3. Patient #6 was admitted on 11/1/07 and discharged on 12/7/07. The hospital transfer summary dated, 11/1/07 revealed: "The patient was a male with a history of severe Alzheimer's dementia, hypertension, hyperlipidemia, who was admitted on the 28th of October 2007 with hypernatremia, with behavior uncontrolled, suggestive of psychosis, hyperchloremia, and dehydration. The patient on admission was put on IV (intravenous) fluids of D5W (dextrose 5%) electrolytes and was monitored. The patient improved. Urine revealed urinary tract infection. The patient was treated with antibiotics. The patient's condition improved on the above management. The patient apparently was doing fine, vital signs stable, more calm and the physical examination was remarkable. The patient is going to be transferred to the gero/psych unit for further management of patient's psychiatric issue." The Geropsych Nursing Physical and Behavioral Documentation form, dated 11/1/07, the information noted (the form was not signed by the nurse) the skin assessment was within normal limits. The licensed nurse documented on the Geropsych Nursing Physical and Behavioral Documentation form dated 11/2/07, the skin assessment was within normal limits.	S 310		

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S 310	Continued From page 11 On 11/14/07, the licensed nurse documented on the skin assessment flowsheet right foot heel (unable to read) the total number of wounds. The wound was measured 6cm x 6cm (centimeter) with no tunneling. The date printed on one photograph was 1/2/05 (preprinted date from the camera) and the other photograph was dated 10/20/05 (preprinted date from the camera). On 11/15/07, a wound consult was done. The physician report revealed: "The patient has 3 second capillary refill to his toes with faint pulses of dorsalis pedia posterior tibialis region. The patient does have a 3 x 3cm blister with some serous drainage with a 1.5 x 1.4 x 0.1 cm ulceration to the proximal aspect of this blister. The blister is located in the medial aspect of the right ankle and extends into the Achilles area. It does not appear to be infected. The area of the ulceration appears to be partial thickness....Plan: 1. Will proceed with the use of hydrogel with ABD (abdominal) pads to the right ankle area daily. 2. I am suggesting no socks to the right foot and no heel protectors offloading the heel so it should take place while the patient is in bed. 3. If necessary, we will drain the fluid from the blister which appears partially ruptured." On 11/15/07, the physician ordered air mattress. The Skin Assessment Flowsheet dated 11/14/07, the licensed nurse documented a right foot heel wound Stage IV which measured 6cm by 6cm. There was no weekly photographs and assessments of the right foot heel taken after 11/14/07. The licensed nurse assessment and the wound care consultant identified the measurement and	S 310		

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S 310	Continued From page 12 the location of the wound. There were discrepancies in the measurements of the wound. The nurse did not follow the hospital protocol for weekly photographing and assessment of the wound. On 11/15/07, a physician order for wound care consult for coccyx decubitus ulcer was obtained. On 11/16/07, a physician's order "for Stage II coccyx decubitus ulcer. Place hydrogel and duoderm dressing q (every) day. Reposition every two hours while in bed." On 11/16/07, 11/17/07, and 11/18/07, there was no documented evidence on the Medication Administration Record, the licensed nurse treated the coccyx area as per the physician's order On 11/20/07, a second wound care consult was ordered. On 11/20/07, the physician ordered the following: "to discontinue hydrogel and duoderm to coccyx. Begin Santyl and Allevyn to coccyx wound every day. Discontinue hydrogel and ABD (type of dressing) to right ankle. Begin Bacitracin and Allevyn to right ankle every day." On 11/21/07, the skin assessment flowsheet documented: the wound located on coccyx wound measured depth zero, width 7cm; 10 cm in length with no tunneling Stage III. A second photograph identified the coccyx wound measured 1.5 cm in length; 0.5cm in width. The photograph was dated 10/3/05. The licensed nurse did not follow the hospital protocol	S 310		

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S 310	Continued From page 13 for assessment and photographing of wounds. On 11/22/07, the skin assessment flowsheet documented; total of one wound; Stage II measured zero depth, 7cm width and 10 cm in length with no tunneling. A photograph was taken. There was no documented evidence to verify the location of the pressure ulcer. On 11/23/07, an physician's order was obtained to start Vitamin C 500 mg (milligrams) by mouth two times a day; Zinc 220mg by mouth daily; and Ensure Plus with each meal. After 11/22/07, there was no documented evidence to verify the licensed nurses photographed and assessed the wounds as per the hospital protocol. On 11/26/07, physician's order revealed "change sacral dressing to Silvadene and Allevyn BID (twice a day). Please keep patient off sacrum." On 12/5/07, physician's order for hospice evaluation. On 12/7/07, the patient was discharged with wound care instructions to hospice. The anticipation was the patient will go to hospice inpatient and then ultimately go home with the wife with continued hospice care. There was no documented evidence to verify the licensed nurse treated, assessed and photographed the decubitus ulcers as per the hospital protocol. Severity: 3 Scope: 1 Complaint #NV16991	S 310		

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS649HOS	A. BUILDING _____ B. WING _____	C 06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH VISTA HOSPITAL	1409 EAST LAKE MEAD BLVD NORTH LAS VEGAS, NV 89030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.